

No. 2
-5-43
-17-39
X36671

Registration District No. 247 Primary Registration District No. 5829 Registrar's No. 31

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Parsons
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 45 about years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Parsons
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ADA ROBINSON

3. (b) If veteran, name war No

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9 year 1947 hour 6:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 10 1947 to Sept 9 1947

4. Sex FEMALE 5. Color or race W

6. (a) Single, widowed, married, divorced INT

6. (b) Name of husband or wife W. M. Robinson

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 3 - 1874
(Month) (Day) (Year)

that I last saw her alive on Sept 8 - 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Brain hemorrhage Duration 8 days

8. AGE: Years Months Days If less than one day

73 4 7 hr. min.

Due to Chorea - Brainlets

Due to _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation House work

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name Bill Cline 9

PHYSICIAN Underline the cause to which death should be charged statistically.

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant W. M. Robinson

(b) Address New Madrid R. 1.

17. (a) Burial (b) Date thereof July 11, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsons

18. (a) Signature of funeral director Roberts and Co.

(b) Address New Madrid, Mo.

19. (a) 10-4-47 (b) Clay De Kueley
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Claude M. Bagan (M. D. or other)

Address Parsons, Mo. Date signed July 11, 1947

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Office No. 2,
District File Number 1047-1311
Date Filed 10-2-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed L. S. H. [Signature]
Licensed Embalmer No. 3803
P. O. Address New Madrid, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. *241*

Primary Registration District No. *5829*

Registrar's No. *31*

1. PLACE OF DEATH:

(a) County *New Madrid*
(b) City or town *Rural*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME *Ada Robinson*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *I* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *W-M, Robinson* 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *may 3*
(Month) (Day) (Year)

8. AGE: Years *73* Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

